MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2006

ROCKY MOUNTAIN HOSPITAL AND MEDICAL SERVICE, INC.
700 Broadway
Denver, Colorado 80273-0001

NAIC Group Code 0671
NAIC Company Code 11011

EXAMINATION PERFORMED BY
DIVISION OF INSURANCE STAFF
AND
INDEPENDENT CONTRACT EXAMINERS
COLORADO DEPARTMENT OF REGULATORY AGENCIES
STATE OF COLORADO

CERTIFICATE OF COPY
Of
REPORT OF EXAMINATION

I, **Marcy Morrison**, Commissioner of Insurance of the State of Colorado, do hereby certify that the attached is a true and correct copy of the duplicate original Report of Market Conduct Examination as of December 31, 2006 now on file for **Rocky Mountain Hospital and Medical Service, Inc.** as a record of the office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal of office at the City and County of Denver this 18th day of July 2008.

Marcy Morrison
Commissioner of Insurance

ROCKY MOUNTAIN HOSPITAL AND MEDICAL SERVICE, INC.
700 Broadway
Denver, Colorado 80273-0001

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2006

Examination Performed by:

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC
David M. Tucker, AIE, FLMI, ACS
Violetta R. Pinkerton, CIE, CPCU, CPIW
John E. Bell

State Market Conduct Examiners

And

Charlotte J. Howell, CIE, MBA
Victor M. Negron, AIE, FLMI

Independent Contract Examiners

March 5, 2008

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of Rocky Mountain Hospital and Medical Service, Inc. was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205(8) and 10-3-1106, C.R.S., which authorize the Commissioner of Insurance to examine insurance companies. We examined the Company's records at its principal office located at 700 Broadway, Denver, Colorado, 80273-0001 and at the Colorado Division of Insurance offices at 1560 Broadway, Suite 850, Denver, Colorado, 80202. The market conduct examination covered the period from January 1, 2006, through December 31, 2006.

The following market conduct examiners respectfully submit the results of the examination.

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

Violetta R. Pinkerton, CIE, CPCU, CPIW

John E. Bell

Charlotte J. Howell, CIE, MBA

Victor M. Negron, AIE, FLMI

TABLE OF CONTENTS

SECTION **PAGE**

COMPANY PROFILE

The following profile is based on information provided by the Company:

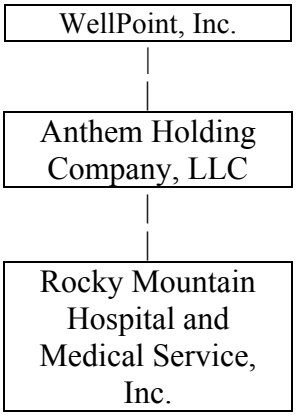
Rocky Mountain Hospital and Medical Service (RMHMS) was formed on January 1, 1978 through the consolidation of Colorado Hospital Service, Inc. and Colorado Medical Service, Inc. into a single non-profit, medical-surgical and health service corporation operated under the trade name of Blue Cross and Blue Shield of Colorado.

RMHMS received its Certificate of Authority in Colorado on March 1, 1978.

On November 16, 1999 RMHMS converted from a non-profit hospital, medical-surgical and health service corporation to a stock property and casualty insurance company and issued its stock to Anthem Insurance Companies, Inc. RMHMS became Rocky Mountain Hospital and Medical Service, Inc. (RMHMS, Inc.), and operates under the trade name Anthem Blue Cross and Blue Shield. RMHMS, Inc. is a wholly owned subsidiary of Anthem Holding Company, LLC, which in turn, is 100% owned by WellPoint, Inc.

RMHMS, Inc. also operates in the State of Nevada under its Certificate of Authority effective December 16, 1999. RMHMS, Inc.'s operational territory includes all counties in Colorado and Nevada.

RMHMS, Inc.'s NAIC Company Code is 11011 and its NAIC Group Code is 671.



Service Area

The Company is licensed to provide services in all counties in Colorado.

Enrollment as of December 31, 2006:	603,353
Total Written Premium:	$220,764,570
Small Group Written Premium:	$3,375,270
Market Share: (Total Accident & Health)	10.01%

Health Care Delivery:

RMHMS, Inc. or the Company contracts with independent physician associations, physician group practices, and independent physicians, as well as hospitals, mental health facilities and other ancillary providers to provide primary and specialty care. The Company pays for health care services through negotiated fee-for-service and per diem arrangements.

PURPOSE AND SCOPE

State market conduct examiners with the Colorado Division of Insurance (Division), who were assisted by independent contract examiners, reviewed certain business practices of Rocky Mountain Hospital and Medical Service, Inc. (the Company). The limited market conduct examination was performed in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8) and 10-3-1106, C.R.S., which empower the Commissioner to examine any entity engaged in the business of insurance. The information in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance laws related to health insurance companies. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

The examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained and/or submitted by the Company. The limited market conduct examination covered the period from January 1, 2006, through December 31, 2006.

The examination included review of the following:

Company Operations and Management
Contract Forms
New Business Applications and Renewals (Some issues deemed from HMOC, Inc. findings.)
Cancellations/Declinations/Terminations/Rescissions
Claims
Utilization Review (Deemed from HMOC, Inc. findings, except dental issue.)

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain any improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to individual, small and large group health insurance laws. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance

percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. The examination was conducted concurrently with an examination of HMO Colorado, Inc. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

During the examination, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although Rocky Mountain Hospital and Medical Service, Inc. and HMO Colorado, Inc. are separate companies, there are certain policies, procedures and forms that are common to both companies.

Therefore, it was agreed that in cases involving utilization review and some underwriting processes, the Division would "deem" the findings to be applicable to both companies, even though the actual findings may have been identified in only one of the companies.

Exhibit 1

Statute/Regulation	Concerning
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-8-513, C.R.S.	Eligibility for coverage under the program.
Section 10-8-521, C.R.S.	Notice to residents.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-103.5, C.R.S.	Payment of Premiums – required term in contract.
Section 10-16-104, C.R.S.	Mandatory coverage provisions.
Section 10-16-105, C.R.S.	Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans – rules – benefit design advisory committee – repeal.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-214, C.R.S.	Group sickness and accident insurance.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-owned Private Passenger Automobile-Type Endorsement Forms, Claims-made Liability Forms and Preneed Funeral Contracts
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-6	Concerning the Definition of the Term "Complications of Pregnancy" for Use in Accident and Health Insurance Contracts and Certificates

Insurance Regulation 4-2-8	Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation Of Health Plan Claims Involving Utilization Review
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued to Self-Employed Business Groups of One
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-6-2	Group Coordination of Benefits.
Insurance Regulation 4-6-5	Concerning Implementation of Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-9	Conversion Coverage

Company Operations and Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

Audits and Examinations

The Company was the subject of a previous limited market conduct examination dated June 28, 2001, which covered the period January 1, 2000 through December 31, 2000. The Company was also the subject of a financial examination conducted by the Division's financial examiners that was completed in November 2004, and covered the period of January 1, 1999 through December 31, 2003.

Contract Forms

The examiners reviewed the following forms:

- The Company's Basic and Standard PPO Plans, copayment schedules and schedules of benefits;
- The Company's most commonly sold PPO group certificates;
- The Company's PPO conversion certificates, application/enrollment forms, and supporting documents; and
- The Company's group and employee PPO applications/enrollment forms and supporting documents.

These plans and related documents were issued and/or certified with the Division between January 1, 2006 and December 31, 2006.

New Business Applications and Renewals

The examiners reviewed:

- A sample of 100 individual new business applications;
- A sample of fifty (50) small group new business application files (Deemed from HMOC, Inc. findings); and

- A sample of fifty (50) small group renewal files (Deemed from HMOC, Inc. Findings).

Cancellations/Terminations/Declinations/Rescissions

The examiners reviewed:

- The entire population of thirty-five (35) rescission files;
- A sample of fifty (50) individual declination files; and
- The entire population of thirty-three (33) small group declination files.

Claims

In order to determine the Company's compliance with Colorado's prompt payment of claims law and the proper and accurate payment of claims, the examiners reviewed the following random samples:

- Fifty (50) electronic claims paid or denied beyond thirty (30) days;
- Fifty (50) non-electronic claims paid or denied beyond forty-five (45) days;
- Fifty (50) claims paid or denied beyond ninety (90) days; and
- Fifty (50) paid and denied claims that were reviewed for accuracy of payment.

Utilization Review

The findings of the utilization review portion of the HMOC, Inc. examination report are "deemed" to also apply to the Rocky Mountain Hospital and Medical Service, Inc. report. The examiners reviewed copies of the Company's Appeals Guide along with its Utilization Review policies and procedures and random samples and/or entire populations of utilization review files in order to determine compliance with Colorado insurance law. The examiners reviewed the following:

- Fifty (50) utilization review approval files;
- Fifty (50) utilization review denial files;
- Fifty (50) first level utilization review appeal files; and
- The entire population of eight (8) voluntary second level utilization review appeal files.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twenty-seven (27) findings in which the Company did not appear to be in compliance with Colorado insurance laws. The following is a summary of the examiners' findings.

Company Operations and Management: The examiners identified two (2) areas of concern in their review of the Company's operations/management:

Issue A1: Failure of the Company, in some instances, to include all required contract provisions in provider contracts.

Issue A2: Failure of the Company to maintain records required for market conduct purposes.

Contract Forms: The examiners identified twelve (12) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and riders):

Issue E1: Failure of the Company's forms, in some instances, to define and/or implement the correct definition of disabled dependent.

Issue E2: Failure of the Company's forms, in some instances, to limit the timeframe of requested medical information to a maximum of five (5) years prior to application.

Issue E3: Failure of the Company to provide coverage to newborns without notification of birth when no further premium is required.

Issue E4: Failure of the Company's forms to properly reflect the eligibility to receive an offer of continuation of coverage. *(This was prior issue E2 in the findings of the market conduct examination report dated June 28, 2001.)*

Issue E5: Failure of the Company to properly title its Basic and Standard health benefit plan certificates.

Issue E6: Failure of the Company's Basic and Standard health benefit plan certificates to correctly define all mandated transplants.

Issue E7: Failure of the Company's Basic and Standard health benefit plan certificates to provide and/or correctly define the mandated children's preventive services.

Issue E8: Failure of the Company's Basic and Standard health benefit plan certificates to provide the mandated adult preventive care services.

Issue E9: Failure of the Company's Basic and Standard health benefit plan certificates to define and/or provide mandated emergency services.

Issue E10: Failure of the Company's forms to provide the required disclosure relating to reimbursement of non-participating providers.

Issue E11: Failure of the Company's forms, in some instances, to provide correct provisions relating to assignment of benefits.

Issue E12: Failure of the Company's certificate of coverage for its HSA Qualified Plans for Individuals to include all required provisions and/or wording mandated by Colorado insurance law.

New Business Applications and Renewals: The examiners identified four (4) areas of concern in their review of the new business application practices of the Company:

Issue G1: Failure to elicit information regarding existing policies and potential replacement of such policies from applicants for individual insurance.

Issue G2: Failure of the Company's individual policies to reflect the amount of premium.

Issue G3: Failure, in some instances, to charge filed premium rates.

Issue G4: Failure, in some instances, to obtain and retain in the file a list of eligible employees and/or eligible dependents.

Cancellations/Declinations/Terminations/Rescissions: The examiners identified five (5) areas of concern in their review of the cancellation/declination/non-renewal practices of the Company:

Issue H1: Failure of the Company's Certificates of Creditable Coverage to address and/or define "significant break in coverage" in accordance with Colorado insurance law.

Issue H2: Failure of the Company to correctly underwrite small employer group applications.

Issue H3: Failure, in some instances, to provide written denial of coverage and/or provide specific reason(s) for denial of coverage on small employer group applications. *(This was prior issue H2 in the findings of the market conduct examination report dated June 28, 2001.)*

Issue H4: Failure, in some instances, to provide price quotes upon request.

Issue H5: Failure, in some instances, to implement procedures for terminating policies, including coding and timing of cancellation processing, and providing offers of Basic and Standard coverage that are in compliance with Colorado insurance law.

Claims: The examiners identified one (1) areas of concern in their review of the claims handling practices of the Company:

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.

Utilization Review: The examiners identified three (3) areas of concern in their review of the Company's Utilization Review procedures.

Issue K1: Failure, in some instances, to provide written notification of first level review adverse determinations within the time frame required by Colorado insurance law.

Issue K2: Failure to provide the location of the review panel meeting and thereby discouraging the covered person from requesting a face-to-face meeting.

Issue K3: Failure to include dental services in the Company's UR procedures.

A copy of the Company's response, if applicable, can be obtained by contacting the Company. Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

ROCKY MOUNTAIN HOSPITAL AND MEDICAL SERVICE, INC.

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure of the Company, in some instances, to include all required contract provisions in provider contracts.

Section 10-16-705, C.R.S., Requirements for carriers and participating providers, states in part:

(1) In addition to any other applicable requirements of this part 7, a carrier offering a managed care plan shall satisfy all the requirements of this section.

(4)(a) Every contract between a carrier and a participating provider shall include provisions for continuity of care as specified in this subsection (4).

(b) Each managed care plan shall allow the covered person to continue receiving care for sixty days from the date a participating provider is terminated by the plan without cause when proper notice as specified in subsection (7) of this section has not been provided to the covered person.

(c) In the circumstance that coverage is terminated for any reason other than nonpayment of premium, fraud, or abuse, *every managed care plan shall provide for continued care for covered persons being treated at an in-patient facility until the patient is discharged*.

(11) A carrier shall not penalize a provider because the participating provider, in good faith, reports to state or federal authorities any act or practice by the carrier that jeopardizes patient health or welfare, or *because the participating provider discusses the financial incentives or financial arrangements between the provider and the managed care plan*.

(14) Every contract between a carrier or entity that contracts with a carrier and participating provider for a managed care plan that requires preauthorization for particular services, treatments, or procedures shall include:

(a) *A provision that clearly states that the sole responsibility for obtaining any necessary preauthorization rests with the participating provider that recommends or orders said services, treatments, or procedures, not with the covered person*;

It appears that the Company is not in compliance with Colorado insurance law in that its provider contracts:

1) Do not clearly state that the sole responsibility for obtaining any required pre-authorization rests with the provider, and not with the Member;

2) Provide for continued care and services only for Members confined to a hospital. This is a more restrictive requirement than "in-patient facility" set forth in Colorado Insurance law. Additionally, the Company's contract does not provide a definition of "hospital" that would include all in-patient facilities;

3) Prohibit the provider from discussing specific payment arrangements, including dollar amounts, with a Member;

The Company's contract states, in part, the following:

ARTICLE I. DEFINITIONS

R. Admissions. Non-Emergency inpatient admissions, specific outpatient procedures, and outpatient surgeries must be approved in advance by Anthem BCBS. *The attending physician shall be responsible for obtaining prior authorization.*

ARTICLE IV. TERM AND TERMINATION

D. Participating Provider shall, upon termination of this Agreement for reasons other than grounds for termination with cause, continue to provide and be compensated for Covered Services to Members under the terms and conditions of this Agreement for 60 days after the effective date of such termination. If coverage is terminated for any reason other than nonpayment of premium, fraud, or abuse, Participating Provider shall continue to provide and be compensated for Covered Services to Members under the terms and conditions of this Agreement *until such Members are discharged from the hospital. For purposes of this Section, "discharge" shall mean the Member's physical release from Hospital.*

ARTICLE V. MISCELLANEOUS PROVISIONS

G. Medical Care Decisions. …Nothing in this Agreement shall prohibit the Participating Provider from disclosing the general methodology by which Participating Provider is compensated under this Agreement, *provided no dollar amounts or other specific terms of the payment arrangement are mentioned to the Member.* [Emphases added.]

Form	Form Number
Participating and PPO Primary Care Provider Agreement	PCP PARPPO: 10/2005

Recommendation No. 1

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-705, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all of its Provider Agreements to include all provisions mandated by Colorado insurance law.

Issue A2: Failure of the Company to maintain records required for market conduct purposes.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states, in part:

(4) Special provisions for small group health benefit plans.

(a) Effective January 1, 1995, *each small employer carrier shall, upon termination of a group policy by the carrier or employer* for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, *offer to any individual the choice of a basic or standard health benefit plan, except as provided in paragraph (b) of this subsection* (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, *cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel.*

(b) If the group's original plan had benefits which were significantly less generous in most respects than the standard plan as determined by the commissioner, the carrier is only required to offer the basic health benefit plan to such group or individual. If an individual is eligible for continuation coverage or conversion coverage pursuant to section 10-16-108 or is eligible for continuation coverage under federal law, then the provisions of paragraph (a) of this subsection (4) and this paragraph (b) shall not apply to such an individual.

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of Section 10-1-109(1), C.R.S., states in part:

Section 4. Records Required For Market Conduct

A. *Every entity subject to the Market Conduct process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations, including but not limited to,* company operations and management, *policyholder services,* claims practices, *rating, underwriting,* marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, utilization review, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two calendar years.

Section 5. Policy Records

A. The following records shall be maintained: *A policy record shall be maintained for each policy issued. Policy records shall be maintained so as to show clearly the policy period, basis for rating* and any imposition of additional exclusions from or exceptions to coverage. If a policy is terminated, either by the insurer or the policyholder, documentation supporting the termination and account records indicating a return of

premiums, if any, shall also be maintained. Policy records need not be segregated from the policy records of other states so long as they are readily available to market conduct examiners as required under this regulation.

B. Policy records shall include at least the following:

(1) *The actual, completed application for each contract, where applicable;*

(a) The application shall bear the signature, either written or digitally authenticated, where required, of the applicant whenever the insurer intends to retain any right to contest any warranty, representation or condition contained in the application; or

(b) The application shall bear a clearly legible means by which an examiner can identify a producer involved in the transaction. The examiners shall be provided with any information needed to determine the identity of the producer;

(2) *Any declaration pages (the initial page and any subsequent pages), the insurance contract, any certificates evidencing coverage under a group contract, any endorsements or riders associated with a policy, any termination notices, and any written or electronic correspondence to or from the insured pertaining to the coverage.* A separate copy of the record need not be maintained in the individual policy to which the record pertains, provided it is clear from the insurer's other records or systems that the record applies to a particular policy and that any data contained in the record relating to that policy, as well as the actual policy, can be retrieved or recreated;

(3) Any binder with terms and conditions that differ from the terms and conditions of the policy subsequently issued; and

(4) *Any guidelines, manuals or other information necessary for the reconstruction of the rating, underwriting, and claims handling of the policy.* Presentation at the site of a market conduct examination of a single copy of each of the above shall satisfy this requirement. *If a rating, underwriting, or claims handling record is computer based, the records used to input the information into the computer system shall also be available to the examiners. These types of records include, but are not limited to, the application, where applicable, the policy form including any amendments or endorsements, rating manuals, underwriting rules, credit reports or scores, claims history reports, previous insurance coverage reports, e.g., MIB questionnaires, internal reports, loans and underwriting and rating notes.* [Emphases added.]

SMALL GROUP CANCELLATION FILES

Population	Sample Size	Number of Exceptions	Percentage to Sample
230	46	46	100%

A random sample of fifty (50) small group cancellation files was selected for review. Four (4) files were excluded because they were either duplicates or outside the examination scope.

It appears that the Company is not in compliance with Colorado insurance law in that it was unable to provide copies of the cancellation notices for any of the forty-six (46) files in the cancellation sample. Therefore, the examiners were unable to determine compliance with the requirement that the Company offer a Basic or Standard health benefit plan to each individual upon cancellation of the group health benefit plan.

The Company was also unable to provide copies of the certificates of creditable coverage that are required when coverage is cancelled. The examiners reviewed regenerated copies of certificates of creditable coverage for twenty-four (24) of those forty-six (46) files. The Company indicated it could not provide certificates for the remaining twenty-two (22) files. The regenerated copies have 2007 and 2008 issue dates on them as the Company stated it can reproduce and provide copies only with current dates. The Company also stated it was unable to provide actual copies or copies regenerated with the actual dates the certificates were mailed.

Additionally, the Company was unable to provide copies of and/or recreate copies of the documents sent to individual policyholders at issue with the information required at delivery to the examiners in a timely manner upon request.

Recommendation No. 2

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 1-1-7. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that all records required for market conduct purposes are maintained and can be provided in a timely manner as mandated by Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure of the Company's forms, in some instances, to define and/or implement the correct definition of disabled dependent.

Section 10-16-102, C.R.S., Definitions, states in part:

> (14) "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and *an unmarried child of any age who is medically certified as disabled and dependent upon the parent.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its "Mentally or Physically Disabled Dependent Enrollment Request" form and its "Enrollment Application and Change Form" are more restrictive than allowed. Colorado insurance law only requires that a dependent be medically certified as disabled; however, the Company's "Mentally and Physically Disabled Dependent Enrollment Request" form includes questions that imply it has a more stringent standard for determining who qualifies as a disabled dependent. Specifically, Colorado insurance law does not consider marital status (other than being "unmarried"), institutionalization, eligibility for care under federal, state or local laws, employment status, degree of disability, or type of disability in determining whether someone qualifies as a disabled dependent.

Additionally, the Company's "Enrollment Application and Change Form" contains a definition of "dependent" that is more restrictive than defined by Colorado insurance law, and its use of the IRS definition of a dependent is potentially misleading to the applicant.

The Company's "Mentally or Physically Disabled Dependent Enrollment Request" form states, in part, the following:

TO BE COMPLETED BY DEPENDENT'S PARENT OR LEGAL GUARDIAN

Dependent Marital Status _ Single _Married _Widowed _Divorced
Was the dependent ever institutionalized? _NO _YES, give name and address of institution and period(s) of confinement
Is the Dependent eligible for care under Federal, State or Local law? _NO _YES, give details
Is, or was, the Dependent employed for wages? _NO _YES, give name and address of current or last employer and average weekly earnings
If the dependent is no longer employed, give reason for termination

TO BE COMPLETED BY DEPENDENT'S PHYSICIAN ONLY

Dependent is presently incapable of self-sustaining employment by reason of: _Mental Disability _Physical Disability
Is the disability congenital? _YES _NO
In your opinion, will dependent ever be capable of self-sustaining employment _YES _NO
Diagnosis of condition causing disability status:

The Company's "Medical – Dental – Vision – Life Enrollment Application and Change Form" states, in part, the following:

7 OVERAGE DEPENDENT AFFIDAVIT

I, the undersigned, verify and attest to the fact that my child(ren) is/are unmarried and financially dependent on me or dependent on me because of a court order and is/are therefore eligible for coverage under this policy. I understand that I am responsible for notifying Anthem Blue Cross and Blue Shield, HMO Colorado or HMO Nevada within 31 days of any changes in my dependent(s) state. I understand that Overage Dependent eligibility must be renewed each year until the maximum age limit is reached, as specified by the Certificate. That coverage is dictated by the actual situation at the time services are rendered and if my child is not qualified as a "dependent", (*A dependent is classified, by the IRS, as a person, other than the taxpayer or spouse, who entitles the taxpayer to claim a dependency exemption when more than 50% financial support is provided or the dependent attends school, full-time, for a minimum of five months in a calendar year.*), at the time services are provided, the charges for those services are not reimbursable and may become my sole responsibility. Anthem Blue Cross and Blue Shield, /HMO Colorado/HMO Nevada reserves the right to request, at anytime, to request proof of overage dependency. [Emphasis added]

Form	Form Number
Mentally or Physically Disabled Dependent Enrollment Form	92203 (Rev. 3-03)
Enrollment Application and Change Form Medical-Dental-Vision-Life	96054 (Rev. 3-03)

Recommendation No. 3

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly define and apply the correct standards for a disabled dependent as mandated by Colorado insurance law.

Issue E2: Failure of the Company's forms, in some instances, to limit the timeframe of requested medical information to a maximum of five (5) years prior to application.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states in part:

> (7) *An individual, corporation, association, partnership, or any other entity engaged in the health insurance business subject to this section shall not request or require from a small group applying for coverage, or from an individual in a small group applying for coverage, medical information going back more than five years before the date of application.* Medical information that is more than five years old on any of the enrollee members of a small group shall not be used by the insurer in underwriting or setting premiums for the group. Nothing in this subsection (7) shall preclude a small group health insurer subject to the provisions of part 2 of this article from asking about the current health status of any of the individuals in a group applying for coverage or from using such information on current health status to underwrite or set premiums for the group as provided by law. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its application form requires individual enrollees of small employer groups to authorize the Company to obtain medical information without limiting the authorization to the maximum five (5) year look-back period. The Company's "Mentally or Physically Disabled Dependent Enrollment Request" form also requests medical information without limiting the time period for that information to the maximum five (5) year limit.

The Company's "Medical – Dental – Vision – Life Enrollment Application and Change Form" states, in part, the following:

> I hereby authorize that:
>
> - At the request of Anthem Blue Cross and Blue Shield, HMO Colorado, HMO Nevada and Anthem Life, *any provider of health services or supplies, insurance company, organization, institution, or person may release information to Anthem Blue Cross Blue Shield, HMO Colorado, HMO Nevada and Anthem Life, about health-related services and supplies provided to me, persons covered under my health coverage, or persons to be covered under my health coverage*. This authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical records.
> - The Medical Review and Underwriting departments or agents of Anthem Blue Cross Blue Shield, HMO Colorado, HMO Nevada and Anthem Life, upon receiving this information my use it to review, investigate, or evaluate any application for an insurance policy, a policy reinstatement, or a request for change in policy benefits;
> - Unless I revoke this authorization, this authorization is valid for 30 months from the date I signed it; and
> - A copy of the authorization is available to me, or to my authorized representative, upon request and will serve as the original. [Emphasis added]

The Company's "Mentally or Physically Disabled Dependent Enrollment Request" form states in part:

TO BE COMPLETED BY DEPENDENT'S PARENT OR LEGAL GUARDIAN

Was the Dependent ever institutionalized? _NO _YES, give name and address of institution and period(s) of confinement

TO BE COMPLETED BY DEPENDENT'S PHYSICIAN ONLY

Is incapacity congenital? _NO _YES

Diagnosis of condition causing handicapped status:

Form	Form Number
Mentally or Physically Disabled Dependent Enrollment Request	92203 (Rev. 3/03)
Enrollment Application and Change Form Medical –Dental – Vision –Life	96054 (Rev. 3-03)

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-105, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to limit its request for personal medical information to a maximum of five (5) years in accordance with Colorado insurance law.

Issue E3: Failure of the Company to provide coverage to newborns without notification of birth when no further premium is required.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

> (1)(a) All group and individual sickness and accident polices and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.
>
> *(d) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of the newborn child and payment of the required premium must be furnished to the insurer or other entity within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one-day period.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy contract forms require notification and/or proof of the birth of a newborn in all cases in order to continue coverage beyond the first thirty-one (31) days following birth, even if payment of a specific premium is not required. The Company's forms do not allow for situations where the newborn is already covered under a member's health benefit contract (i.e., where the member has family coverage) and no additional premium and/or notification of birth is required.

The Company's contract forms state, in part, the following:

Dependents

A Subscriber's Dependents may include the following:

- **Newborn Child.**
- *To continue the newborn child's participation in the coverage beyond the 31-day period after the newborn child's birth, the Subscriber must complete and submit an [Enrollment Application/Change Form] to add the newborn child as a Dependent child to the Subscriber's policy. We must receive the [Enrollment Application/Change Form] within 31 days after the birth of the child to continue coverage for the 32nd day and thereafter*.

Form	Form Number
(Premier, Copay, GenRX, HSA)[PPO_HSA-Qualified]) for Small Group	98887_csm (11-05)
Colorado HSA-Qualified Plans for Individuals	98840 (Rev 1-06) v4
BluePrefered for Group	98780_PPO_AF (6-04) v2

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly reflect coverage of newborns in compliance with Colorado insurance law.

Issue E4: Failure of the Company's forms to properly reflect the eligibility to receive an offer of continuation of coverage. *(This was prior issue E2 in the findings of the market conduct examination report dated June 28, 2001.)*

Section 10-16-108, Conversion and continuation privileges, states, in part:

(1) Group sickness and accident insurance – conversion privileges.

(b) Every group sickness and accident insurance policy included within the provisions of section 10-16-214(1) shall contain a provision which permits every covered employee whose employment is terminated, if the policy remains in force for active employees of the employer, to elect to continue the coverage for himself and his dependents. Such provision shall conform to the requirements, where applicable, of subparagraph (XVII) of paragraph (d) and paragraphs (e) and (f) of this subsection (1).

(d) (XIX) The employer shall not be required to *offer* continuation of coverage of any person if such person is covered by medicare, Title XVIII of the federal "Social Security Act," or medicaid, Title XIX of the federal "Social Security Act."

(e) (I) Upon the termination of employment of an eligible employee, the death of any such employee, or the change in marital status of any such employee, *the employee or dependent has the right to continue the coverage for a period of eighteen months* after loss of coverage or until such employee or dependent becomes *eligible for other group coverage*. However, should new coverage exclude a condition covered under the continued plan, coverage under the prior employer's plan may be continued for the excluded condition only for the eighteen months or until the new plan covers the condition, whichever occurs first. [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its contract forms provide that continuation coverage will terminate when the Member becomes entitled to Medicare benefits.

Colorado insurance law states that an offer of continuation of coverage need not be extended if the Member is *already* covered by Medicare or Medicaid when they become eligible for continuation of coverage. However, as neither Medicare nor Medicaid is "group" coverage, the carrier is not allowed to terminate coverage solely because a Member *becomes eligible* for and/or *covered by* Medicare or Medicaid while enrolled in continuation coverage.

The Company's contract forms state, in part, the following:

Termination of State Continuation Coverage or COBRA

Continuation coverage may terminate before the continuation period expires if:

- You become covered by Medicare

Form	Form Number
(Premier, Copay, GenRX, HSA)[PPO_HSA-Qualified]) For Small Group	98887_csm (11-05)
BluePrefered for Group	98780_PPO_AF (6-04) v2
PPO Basic for Group	98701_PPO Basic (Rev. 1-06) v1
PPO Standard	95981_PPO Standard (Rev. 1-06) v1

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly reflect eligibility for continuation of coverage in accordance with Colorado insurance law.

In the market conduct examination for the period January 1, 2000 to December 31, 2000, the Company was cited for failure of the forms to provide for continuation of coverage according to the provisions of Colorado insurance law. The violation resulted in Recommendation #18 of Stipulated Final Agency Order O-02-120 that the Company "shall revise its forms to indicate that continuation of coverage rights will not be cancelled except as allowed under Colorado insurance law. Failure to comply with the previous order of the Commissioner may constitute a knowing violation of §10-1-205, C.R.S.

Issue E5: Failure of the Company to properly title its Basic and Standard health benefit plan certificates.

Colorado Insurance Regulation 4-6-5, CONCERNING THE BASIC AND STANDARD HEALTH BENEFIT PLANS, promulgated pursuant to §§10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

4. Rules

   A. Plans

      1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small group market pursuant to §10-16-105(7.3), C.R.S. and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan or to those individuals purchasing a basic conversion plan.

      2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

   B. *The basic and standard health benefit plans shall be identified as specified below.*

      1. Each small employer carrier *shall title* and market its basic health benefit plan as follows: "[Carrier name][Type of plan (i.e., Indemnity, Preferred Provider or HMO) (*Basic Limited Mandate Health Benefit Plan, Basic HSA Health Benefit Plan or Basic HSA Limited Mandate Health Benefit Plan*)] *for Colorado*."

      3. Each small employer carrier *shall title* and market the standard health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider, or HMO] *Standard Health Benefit Plan for Colorado*." [Emphases added.]

It appears the Company is not in compliance with Colorado insurance law in that its Basic and Standard health benefit plan contract forms are not correctly titled pursuant to the Colorado Insurance Regulation 4-6-5. The health plan description forms issued in conjunction with the Company's Basic and Standard health benefit plan contracts also fail to reflect the correct titling as required by Colorado insurance law.

The Company's Basic and Standard health benefit plan contracts (and health plan description forms) are titled as listed below. The "Basic" plan titles do not reflect the titling required by Colorado insurance law and do not allow the Examiners, nor the Members, to determine which of the three (3) designated Basic health benefit plans are being offered. The "Standard" health benefit plan does not reflect the complete title required by Colorado Insurance law.

Form	Form Number
PPO Standard BA81	95891_PPO Standard (Rev. 1-06) v1
PPO Standard BA81 CR09	98028 (Rev. 4-06) v2 x8x9
PPO Standard Group Conversion	95981_GC (Rev. 1-06) v1
PPO Basic for Group BA82	98701_PPO Basic (Rev. 1-06) v1
PPO Basic BA82 CR06	98029 (Rev. 4-06) v1 x7y9
PPO Basic for Group Conversion	98701_GC (Rev. 1-06) v1

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its Basic and Standard health benefit forms to reflect the proper titles in accordance with Colorado insurance law.

Issue E6: Failure of the Company's Basic and Standard health benefit plan certificates to correctly define all mandated transplants.

Amended Regulation 4-6-5, CONCERNING THE BASIC AND STANDARD HEALTH BENEFIT PLANS, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., effective January 1, 2006, states in part:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

I. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan*", "*Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".*

II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan*." [Emphases added.]

Benefit Grids:

JANUARY 1, 2006 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	BASIC INDEMNITY PLAN	**BASIC PREFERRED PROVIDER PLAN**		**BASIC HMO PLAN**
		IN-NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
24. ORGAN TRANS-PLANTS[18]	*Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas*, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. [Emphasis added]			
	50% coinsurance	70% coinsurance	50% coinsurance	Coverage is no less extensive than the coverage for any other physical illness.

18. Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

JANUARY 1, 2006 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
24. ORGAN TRANS-PLANTS[22]	Covered transplants include: *liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas*, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. [Emphasis added]			
	80% coinsurance	80% coinsurance	60% coinsurance	Coverage is no less extensive than the coverage for any other physical illness.

22. Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

It appears that the Company is not in compliance with Colorado insurance law in that the description of covered transplant procedures contained in the Company's health benefit plan contracts provides coverage for transplants that are not included in the Colorado basic and standard plans.

The Company's contract forms appear to provide coverage for stand-alone pancreatic transplant, in excess of the mandated benefits required under Colorado Insurance Regulation 4-6-5.

The examiners note that the Company's "Colorado Health Plan Description Form(s)", used as the co-payment schedule for the Company's basic and standard plans, do contain the correct description of the mandated transplant coverage. However, this form states: "**Important Note**: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contain all terms, covenants and conditions of coverage." This language appears to restrict benefits for transplants to those listed in the contract and is misleading and confusing to the Member in regard to their benefits.

The Company's contracts state, in part, the following:

Human Organ and Tissue Transplant Services

Benefits are provided, when pre-authorized by Anthem, for services directly related to the following transplants:

- Heart
- Lung (single or double)
- Heart-Lung
- Kidney
- Kidney-Pancreas
- *Pancreas*
- Liver
- Bone marrow for a member with Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high-risk state II or III breast cancer or Wiskott-Aldrich syndrome
- Peripheral stem cell procedures for the same procedures list above under bone marrow
- Cornea [Emphasis added]

Form	Form Number
PPO Standard BA81	95981_PPO Standard (Rev. 1-06) v1
PPO Standard Group Conversion	95981_GC (Rev. 1-06) v1
PPO Standard Health Benefit Plan BA81 CR09	98028 PPO Standard (Rev. 4-06) v2 x8 x9
PPO Basic for Group BA82	98701_PPO Basic (Rev. 1-06) v1
PPO Basic for Group Conversion	98701_GC (Rev. 1-06) v1

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly reflect the mandated transplant coverage in accordance with Colorado insurance law.

Issue E7: Failure of the Company's Basic and Standard health benefit plan certificates to provide and/or correctly define the mandated children's preventive services.

Colorado Insurance Regulation 4-6-5, CONCERNING THE BASIC AND STANDARD HEALTH BENEFIT PLANS, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., effective January 1, 2006, states in part:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan*", "*Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".*

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan*." [Emphases added.]

Benefit Grids:

JANUARY 1, 2006 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	BASIC INDEMNITY PLAN	**BASIC PREFERRED PROVIDER PLAN**		**BASIC HMO PLAN**
		IN-NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
9.PREVENTIVE CARE[6] a) **Children's services** (No deductible prior to applica-tion of co-insurance.) **b) Adults'**	For all plans, only specified preventive services are covered.			

services[6a]				
	50% coinsurance	$40 copay/visit.	50% coinsurance	$40 copay/visit.
	50% coinsurance	$40 copay/visit	50% coinsurance	$40 copay/visit.

6 See Attachment 1 for list of covered preventive services. Immunization schedule will be published in a bulletin that will be updated yearly.

6a Prostate cancer screening and routine mammograms are not covered.

JANUARY 1, 2006 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
	For all plans, only specified preventive services are covered.			
9. PREVENTIVE CARE[6]				
a) **Children's services** (No deductible prior to application of coinsurance.)	80% coinsurance	$25 copay/visit.	50% coinsurance	$25 copay/visit.
b) **Adult's services**	80% coinsurance	$25 copay/visit	50% coinsurance	$25 copay/visit

6 See Attachment 1 for list of covered preventive services. Immunization schedule will be published in a bulletin that will be updated yearly.

Attachment 1

Covered Preventive Services [1]	
Age 7 – 12	3 well-child visits
Age 13 - 18	1 age appropriate health maintenance visit[3] every year

2. "Well-child visit means a visit to a primary care provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling.

3. "Age appropriate health maintenance visit" means an exam which includes the following components: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.), and exercise and nutritional counseling (including foliate counseling for women of child bearing age).

It appears that the Company is not in compliance with Colorado insurance law in that neither the Company's Basic or Standard health benefit plan contracts provide the definition of what is included with the "well-child" or "age appropriate" health maintenance visits.

The Company's PPO Basic contracts state, in part, the following:

Preventive Care Services

Children

Age 7-18

- One health maintenance visit every year.

Form	Form Number
PPO Standard BA81	95981_PPO Standard (Rev. 1-06) v1
PPO Standard Group Conversion	95981_GC (Rev. 1-06) v1
PPO Basic for Group BA82	98701_PPO Basic (Rev. 1-06) v1
PPO Basic for Group Conversion	98701_GC (Rev. 1-06) v1

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly define and provide the mandated children's preventive services in accordance with Colorado insurance law.

Issue E8: Failure of the Company's Basic and Standard health benefit plan certificates to provide the mandated adult preventive care services.

Colorado Insurance Regulation 4-6-5, CONCERNING THE BASIC AND STANDARD HEALTH BENEFIT PLANS, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., effective January 1, 2006, states in part:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

3. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan*." [Emphases added.]

Benefit Grids:

JANUARY 1, 2006 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN		STANDARD HMO PLAN
		IN-NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
	For all plans, only specified preventive services are covered.			

9. PREVENTIVE CARE[6]				
b) **Children's services** (No deductible prior to application of coinsurance.)	80% coinsurance	$25 copay/visit.	50% coinsurance	$25 copay/visit.
b) **Adult's services**	80% coinsurance	$25 copay/visit	50% coinsurance	$25 copay/visit

7 See Attachment 1 for list of covered preventive services. Immunization schedule will be published in a bulletin that will be updated yearly.

Attachment 1

Covered Preventive Services [1]	
Age 40 – 64	Males: Prostate screening as specified in state law **(Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.)**
Age 65 and older	Males: Prostate screening as specified in state law **(Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.)**

It appears that the Company is not in compliance with Colorado insurance law in that the description of preventive care services for prostate screening for men is excluded from coverage in the Company's "PPO Standard" and "PPO Standard Group Conversion" health benefit plan contracts. The examiners note that the Company's contracts do list the correct prostate cancer screening benefits and maximum payments required under Colorado Insurance Regulation 4-6-5. However, these benefits are also listed as exclusions from coverage in the same section. This contradiction is potentially confusing to the Member as to what benefits are actually covered under these plans.

The Company's PPO Standard Health Benefit Plan contracts state, in part, the following:

Preventive Care Services

Men

Age 40 years and older

- One prostate specific antigen (PSA) blood test and digital rectal examination per year

Preventive Care Exclusions – The following services, supplies and care are not covered:

- Prostate cancer screening

Form	Form Number
PPO Standard BA81	95981_PPO Standard (Rev. 1-06) v1
PPO Standard Group Conversion	95981_GC (Rev. 1-06) v1

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly cover adult preventive services in accordance with Colorado insurance law.

Issue E9: Failure of the Company's Basic and Standard health benefit plan certificates to define and/or provide mandated emergency services.

Colorado Insurance Regulation 4-2-17, PROMPT INVESTIGATION OF HEALTH PLAN CLAIMS INVOLVING UTILITATION REVIEW AND DENIAL OF CLAIMS, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, C.R.S., states in part:

Section 8 Emergency Services

A. *A health carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.* Under these same circumstances, a claim for emergency services necessary to screen and stabilize a covered person shall not be denied for failure of the covered person or the emergency service provider to secure prior authorization. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, a health carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent lay person would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency, of if a provision of federal, state or local law require the use of a specific provider. [Emphasis added]

It appears that the Company is not in compliance with Colorado insurance law in that its PPO health benefit plan contract forms appear to preclude payment of ambulance transport when used in conjunction with treatment and transport for emergency services.

The Company's PPO health benefit plan contracts state, in part, the following:

Ambulance and Transportation Services

Ambulance services are a Covered Service *only when Medically Necessary* and:

- *When ordered by an employer, school, fire or public safety official and you are not in a position to refuse*; [Emphases added]

Form	Form Number
PPO Standard BA81	95981_PPO Standard (Rev. 1-06) v1
PPO Standard Group Conversion	95981_GC (Rev. 1-06) v1
PPO Basic for Group BA82	98701_PPO Basic (Rev. 1-06) v1
PPO Basic for Group Conversion	98701_GC (Rev. 1-06) v1
(Premier, Copay, GenRX, HSA)[PPO_HSA Qualified]] for Small Group	98887_csm (11-05)

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly reflect the mandated coverage for emergency treatment in accordance with Colorado insurance law.

Issue E10: Failure of the Company's forms to provide the required disclosure relating to reimbursement of non-participating providers.

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration – repeal, states in part:

(2)(d) *The carrier shall provide, in conspicuous, bold-faced type, an understandable disclosure in policy contract materials, certificates of coverage for a policyholder, and marketing materials about the following*:

(III) The mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers for specific covered health care services.

(e) (I) A carrier shall make available upon request from the covered person or the nonparticipating provider from whom the covered person is seeking treatment, the carrier's usual, customary, and reasonable rate for reimbursement for specific health care services.

It appears that the Company is not in compliance with Colorado insurance law in that its PPO health benefit plan contracts do not provide the required disclosure relating to obtaining reimbursement rates for nonparticipating providers as required by the above paragraphs of Section 10-16-704, C.R.S.

The Company's PPO health benefit plan contracts state, in part, the following:

Non-PPO Providers (Out-of-Network)

Non-Participating Providers – Provider who have not signed agreements with Us are Non-Participating Providers. You may be obligated to pay more Out-of-Pocket expenses when you visit a Non-Participating Provider. Non-Participating Providers are not required to accept our Maximum Benefit Allowance as payment in full. They may bill you directly for any amount over Our Maximum Benefit Allowance for a Covered Service. You may pay any difference between Our Maximum Benefit Allowance and the Non-Participating Provider's Billed Charges.

Form	Form Number
PPO Standard BA81	95981_PPO Standard (Rev. 1-06) v1
PPO Standard Group Conversion	95981_GC (Rev. 1-06) v1
PPO Basic for Group BA82	98701_PPO Basic (Rev. 1-06) v1
PPO Basic for Group Conversion	98701_GC (Rev. 1-06) v1
Colorado HSA-Qualified Plans for Individuals (Premier, Copay, GenRX, HSA)[PPO_HSA Qualified]] for Small Group	98840 (Rev. 1-06) v4 98887_csm (11-05)

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to contain the required disclosure relating to reimbursement of non-participating providers in accordance with Colorado insurance law.

Issue E11: Failure of the Company's forms, in some instances, to provide correct provisions relating to assignment of benefits.

Section 10-16-106.7., C.R.S., Assignment of health insurance benefits, states, in part:

> (1)(a) *Any carrier that provides health coverage to a covered person shall allow, but not require, such covered person under the policy to assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist as described in section 6-1-707 (1) (c), C.R.S., or a massage therapist, also referred to in this section as the "provider", for services provided to the covered person that are covered under the policy.*
>
> (2)(b) *The carrier shall honor the assignment and make payment of covered benefits directly to the provider.* If the carrier fails to honor the assignment by making payment to the covered person and if the covered person, upon receipt of such payment, fails to pay an amount equivalent to such payment to the provider within forty-five days, the carrier shall be liable for the payment directly to the provider. It shall be the responsibility of the provider to notify the carrier if payment has not been received. In such case, the carrier shall make payment of covered benefits. [Emphasis added.]

It appears the Company is not in compliance with Colorado insurance law in that the Company's Certificate of Coverage, HSA Qualified Plans for Individuals (Form 98840 (Rev. 1-06, v4)) includes a provision on page 45 that states:

> "Anthem is not required to honor an assignment of benefits to non-participating providers. Anthem may honor an assignment of benefits to non-participating providers at Anthem's sole discretion. If Anthem pays the member directly, the member is responsible or paying the non-participating provider of services for all charges."

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-106.7, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly reflect the assignment of benefits provisions in accordance with Colorado insurance law.

Issue E12: Failure of the Company's certificate of coverage for its HSA Qualified Plans for Individuals to include all required provisions and/or wording mandated by Colorado insurance law.

Section 10-16-102, C.R.S., Definitions states, in part:

(30) "Policy of sickness and accident insurance" means any policy or contract of insurance against loss or expense resulting from the sickness of the insured, or from the bodily injury or death of the insured by accident, or both.

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states in part:

(1) Except as provided in section 10-16-204, *each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section;* except that the insurer, at its option, may substitute for one or more of such provisions corresponding *provisions of different wording approved by the commissioner* which are in each instance not less favorable in any respect to the insured or the beneficiary. *Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.*

(2) A provision as follows: *"Entire contract--changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions."*

(4)(a) A provision as follows: *"Grace period:* A grace period of ..... (insert a number not less than '7' for weekly premium policies, '10' monthly premium policies, and '31' for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

(b) A policy in which the insurer reserves the right to refuse any renewal *shall have, at the beginning of the provision referred to in paragraph (a) of this subsection (4), "Unless not less than thirty days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted,".*

(5)(a) A provision as follows: "*Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional*

receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application "

(6)(a) Provisions as follows: "*Notice of claim: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer."*

(7) A provision as follows: *"Claim forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made."*

(8) A provision as follows: *"Proofs of loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, if such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required."*

(9) A provision as follows: *"Time of payment of claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."*

(10)(a) A provision as follows: *"Payment of claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be*

paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(11) A provision as follows*: "Physical examinations and autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."*

(12) A provision as follows: *"Legal actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished."*

(13)(a) A provision as follows: *"Change of beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy." [Emphases Provided]*

Section 10-16-203, C.R.S., Optional provisions in individual sickness and accident insurance policies, states in part:

(1) Except as provided in section 10-16-204, *no individual sickness and accident insurance policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section*; except that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording *approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.*

(5)(a) A provision as follows: *"Insurance with other insurers: If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the 'like amount' of such other coverage shall be taken as the amount*

which the services rendered would have cost in the absence of such coverage."

(b) *If the foregoing policy provision is included in a policy which also contains the policy provisions in subsection (6) of this section, there shall be added to the caption of the foregoing provision the phrase "..... Expense incurred benefits". The insurer may include in this provision, at its option, a definition of "other valid coverage", approved as to form by the commissioner,* which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. *In the absence of such definition, such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations.* For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. *In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage".*

(6)(a) A provision as follows: "Insurance with other insurers: If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined."

(b) *If the policy provision set forth in paragraph (a) of this subsection (6) is included in a policy which also contains the policy provision in subsection (5) of this section, there shall be added to the caption of the provision set forth in paragraph (a) of this subsection (6) the phrase "..... Other benefits". The insurer may include in this provision, at its option, a definition of "other valid coverage", approved as to form by the commissioner,* which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada and to any other coverage the inclusion of which may be approved by the commissioner. *In the absence of such definition, such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefits provided for such insured pursuant to any compulsory benefit*

> *statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision, no third-party liability coverage shall be included as "other valid coverage". [Emphases Added)*

Section 10-16-205, C.R.S, Order of certain policy provisions in individual policies of sickness and accident insurance, states:

> The provisions which are the subject of sections 10-16-202 and 10-16-203, or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in the consecutive order of the provisions in such sections, or, at the option of the insurer, any such provision may appear as a unit in any part of the policy with other provisions to which it may be logically related, but the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

Section 10-16-107, C.R.S. Rate regulation rules - approval of policy forms - benefit certificates - evidences of coverage - loss ratio guarantees - disclosures on treatment of intractable pain, states in part:.

(2) No policy of sickness and accident insurance or subscription certificate or membership certificate or other evidence of health care coverage shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application that becomes a part of any such policy, contract, or evidence of coverage be used, until the insurer has filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of the insurer's good faith knowledge and belief, to Colorado law pursuant to section 10-16-107.2 and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.

(3)(b) An evidence of coverage shall contain:

(I) No provisions or statements which are unjust, unfair, inequitable, *misleading,* or deceptive, *which encourage misrepresentation*, or which are *untrue, misleading,* or deceptive as defined in section 10-16-413 (1); and

(II) A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:

(D) *The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts*, or an indication whether the plan is contributory or noncontributory with respect to group certificates;

(d) A copy of the form of the evidence of coverage to be used in this state, and any amendment thereto, shall be subject to the filing and approval requirements of section 10-16-107.2 unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or nonprofit hospital, medical-surgical, and health service corporations in which event the filing and approval provisions of subsection (2) of this section shall apply. To

the extent, however, that such provisions do not apply, the requirements in paragraph (b) of this subsection (3) shall be applicable. [Emphases Added}

Section 10-3-1104, C.R. S., Unfair methods of competition and unfair or deceptive acts or practices states, in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(a) *Misrepresentations* and false advertising of insurance policies: Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, circular, *statement,* sales presentation, omission, or comparison which:

(I) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy;…[Emphases Added}

Issue (1): It appears the Company is not in compliance with Colorado insurance law in that the Certificate of Coverage for its HSA Qualified Plans for Individuals (Form 98840 (Rev. 1-06) v4), which it has stated is the "policy", does not include all required provisions for individual policies in the words in which the provisions appear in Section 10-16-202, C.R.S. There is no "Entire contract" provision or "Change of beneficiary" provision.

Issue (2): It appears the required provisions that are included in the Company's policy are not all in the words in which the provisions appear in Section 10-16-202, C.R.S. The certificate does include a reinstatement provision as well as provisions required to be captioned "Notice of claim", "Claims forms", "Proofs of loss", "Time payment of claims", and "Payment of Claims". However, those provisions are not in the words in which the provisions appear in statute.

Issue (3): It appears the provisions included in the policy are sometimes not preceded individually by the captions appearing in the statute. Example: The required caption "Grace Period" is missing on page 44 and the required captions "Physical Examination and Autopsy" and "Legal Actions" are missing on page 72.

Issue (4): Certain provisions are permitted at the option of the insurer, but if included, are required to be in the words in which the provisions appear in Section 10-16-203, .C.R.S. There are no provisions captioned "Other insurance in this insurer", "Insurance with other insurers", which has additional options, and "Expense incurred benefits"; however, there are provisions on pages 49-51 that appear to be the Company's provisions regarding other insurance. Therefore it appears these optional provisions are included but are not in the words in which the provisions appear in the statute. Some of these incorrect provisions are on pages 49, 50, and 51, under the italicized headings "Workers' Compensation", "Automobile Insurance Provisions" and "Third Party Liability: Subrogation"

Issue (5): The Company's form appears to be out of compliance in that it appears one statement is not applicable and is therefore untrue and could be misleading. The section under Automobile Insurance Provisions at the bottom of page 49 includes reference to the Colorado Auto Accident Reparations Act, which sunset in 2003. This inclusion of a statute which provides for a coverage that is no longer available is untrue and could be misleading.

Issue (6): The Company's form appears to be out of compliance in that there are references in the Certificate of Coverage for individual policies to "group" and "life" coverage. These references to "group" and "life" coverage appear to be untrue for individual coverage and could be misleading. The words in a footnote on a letter, which appears to be a disclosure and the arrangement of the policy provisions in the Certificate of Coverage also appear to be misleading.

On page 55 of the certificate, under the title of Glossary, there is a definition of Anniversary Date that references a group renewal. At the bottom of the letter on which the ID card is affixed to be mailed is a disclosure in very small print which references a group subscriber. The language on that page states, in part:

> "By accepting this card and any benefits to which this card entitles the holder, the holder acknowledges that the agreement pursuant to which this card is issued constitutes a contract solely between the group subscriber/subscriber and Anthem Blue Cross and Blue Shield…"

Page 70 of Colorado HSA-Qualified Plans for Individuals (Form 98840(Rev. 1-06) v4) is titled "Part 2: Anthem Life Accidental Death and Dismemberment and Loss of Sight Benefits" and in addition to the above form number, includes Form No. 96150. At the top of pages 70-72 is added the word "Life" as if to identify this form as separate from the health coverage of the policy. Under the caption "General Provisions" on page 72 are provisions with words and format closer to the words and format required by and provided in Sections 10-16-202, (10-13), C.R.S., than the provisions included on pages 45, 46 and 54 of Part 1. Including these words on page 72, only in this Part 2, and not on pages 45, 46 and 54 in Part 1 gives the impression that the provisions in those words apply only to the accidental death and dismemberment and loss of sight benefits of this policy. That impression is incorrect and untrue and therefore this segregation is a misleading and deceptive practice.

Such references to "group" and "life" coverage, the inclusion of untrue and misleading statements, and the segregation of certain provisions, in an individual policy of sickness and accident insurance, are misleading and could be considered an unfair or deceptive act or practice in the business of insurance.

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-102, 10-16-107, 10-16-202, 10-16-203, 10-16-205 and 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its certificates of coverage for individual plans to comply with all requirements of Colorado insurance law.

NEW BUSINESS APPLICATIONS AND RENEWALS

Note: Some of the findings in the New Business Applications and Renewals Section were identified in the market conduct examination of HMO Colorado, Inc., but were deemed to also apply to Rocky Mountain Hospital and Medical Service, Inc.

Issue G1: Failure to elicit information regarding existing policies and potential replacement of such policies from applicants for individual insurance.

Colorado Insurance Regulation 4-2-1, Replacement of Accident and Health Insurance, states in part:

Section 4. Definitions

A. *Application forms shall include the following questions* designed to elicit information as to whether, as of the date of the application, the applicant has accident and sickness insurance in force or whether accident and sickness insurance is intended to replace or be in addition to any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements may be used.

[Statements]

(1) You normally do not require more than one policy.
(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
(3) You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.
(4) If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

[Questions]

To the best of your knowledge:

(1) Do you have another insurance policy or contract in force?
  (a) If so, with which company?
  (b) If so, do you intend to replace your current accident and sickness insurance with this policy (contract)?
(2) Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy?
  (a) What kind of policy?
(3) Are you covered for medical assistance through the state Medicaid program:

  (a) As a Specified Low Income Medicare Beneficiary (SLMB)?
  (b) As a Qualified Medicare Beneficiary (QMB)?
  (c) For other Medicaid medical benefits?

C. In the case of a direct response insurer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, *shall be returned to the applicant by the insurer* upon delivery of the policy.

D. *Upon determining that a sale will involve replacement of accident and sickness insurance, any issuer,* other than a direct response issuer, or its producer, *shall furnish the applicant,* prior to issuance or delivery of the accident and sickness insurance policy or contract, *a notice regarding replacement of accident and sickness insurance.* One (1) copy of such notice signed by the applicant and producer, except where the coverage is [s]old (sic) without a producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. *A direct response issuer shall deliver to the applicant, at the time of issuance of the policy,* The Notice to Applicant Regarding Replacement of Accident and Sickness Insurance, located in Appendix A of this regulation.

E. *The Notice* to Applicant Regarding Replacement of Accident and Sickness Insurance (Appendix A) required by Subsection D above for an issuer, *shall be provided in the format prescribed and adopted by the Commissioner of Insurance.*

G. Failure to comply with the requirements of this Section 5 constitutes an unfair method of competition and an unfair or deceptive act or practice in the business of insurance which is prohibited under §10-3-1104, C.R.S. [Emphases added.]

INDIVIDUAL NEW BUSINESS APPLICATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
7,631	100	91	91%

It appears the Company is not in compliance with Colorado insurance law in that ninety-one (91) of the 100 files reviewed either didn't include the replacement coverage statement or questions, or contained information that indicated coverage would be replaced but did not include documentation that the required notice regarding replacement was provided to the applicant.

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-1. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its application forms and underwriting processes and procedures to properly elicit replacement information in accordance with Colorado insurance law.

Issue G2: Failure of the Company's individual policies to reflect the amount of premium.

Section 10-16-201, C.R.S., Form and content of individual sickness and accident insurance policies, states in part:

(1) No such policy shall be delivered or issued for delivery in this state unless:

(a) *The entire money and other considerations therefor are expressed therein*; and
(b) The time at which insurance takes effect and terminates is expressed therein; and
(c) It purports to insure only one person, except as provided in sections 10-16-214 and 10-16-215, and except that a policy or contract may be issued upon the application of an adult member of a family, who shall be deemed the policyholder, covering members of any one family, including husband, wife, dependent children or any children under the age of nineteen, and other dependents living with the family; and
(d) Every printed portion of the text matter and of any endorsements or attached papers is printed in uniform type of which the face is not less than ten-point; the "text" shall include all printed matter except the name and address of the insurer, name and title of the policy, captions, sub-captions, and form numbers; but, notwithstanding any provision of this article, the commissioner shall not disapprove any such policy on the ground that every printed portion of its text matter or of any endorsement or attached paper is not printed in uniform type if it is shown that the type used is required to conform to the laws of another state in which the insurer is licensed; and
(e) The exceptions and reductions of indemnity are adequately captioned and clearly set forth in the policy or contract; and
(f) Each such form, including riders and endorsements, is identified by a form number in the lower left-hand corner of the first page thereof. [Emphasis added.]

INDIVIDUAL NEW BUSINESS APPLICATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
7,631	100	100	100%

It appears the Company is not in compliance with Colorado insurance law in that none of the 100 files reviewed included documentation showing that the premium amount was included in the policy packet delivered or issued for delivery to applicants for new individual coverage.

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-201, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policy contract forms to properly reflect premium amounts in accordance with Colorado insurance law.

Issue G3: Failure, in some instances, to charge filed premium rates.

Section 10-16-107, C.R.S., Rate regulation - approval of policy forms - benefit certificates - evidences of coverage - loss ratio guarantees - disclosures on treatment of intractable pain, states in part:

> (2) No policy of sickness and accident insurance or subscription certificate or membership certificate or other evidence of health care coverage shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application that becomes a part of any such policy, contract, or evidence of coverage be used, until the insurer has filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of the insurer's good faith knowledge and belief, to Colorado law pursuant to section 10-16-107.2 *and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.* [Emphasis added.]

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (f)(II) Unfair discrimination: Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

Colorado Insurance Regulation 4-2-11, Rate Filing And Annual Report Submissions Health Insurance states in part:

Section 4 Definitions

> M. "Rate Filing" means, for purposes of this regulation, is a filing that contains all of the items required in this regulation and the bulletin entitled “Requirements for the Filing of Rate and Forms for Life, Accident and Health Carriers”, and 1) for individual products, the proposed base rates and all rating factors, the underlying rating assumptions; and 2) for group products, the underlying rating factors and assumptions, and support for changes in these factors and assumptions.

Section 5 General Rate filing Requirements

> A. General Requirements
>
> 1. Required Submissions:
>
> a. All companies must submit rate filings whenever the rates charged new or renewal policy holders or certificateholders differ from the rates on file with the Division of Insurance. Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology, or changes(s) in the trend or other rating

assumptions. A company may file changes to the base rates or the index rate, for small group rate filings, due solely to trend for a maximum of one year. The continued use of a trend or any other continuing assumption is required to be verified at least annually for continued appropriateness.

INDIVIDUAL NEW BUSINESS APPLICATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
7,631	100	10	10%

It appears the Company is not in compliance with Colorado insurance law in that in some instances the rates charged on new individual policies do not match the filed rates. Using rates that differ from filed rates is a form of unfair discrimination in that individuals with similar rate characteristics and/or similar expenses are not charged similar rates. In addition, using any rate not specifically filed for use is a violation of Colorado insurance law.

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-107 and 10-3-1104, and Colorado Insurance Regulation 4-2-11. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its systems and rating procedures to ensure that rates are applied consistently among all individuals, and as outlined in the rate filings submitted to the Division in accordance with Colorado insurance law.

Issue G4: Failure, in some instances, to obtain and retain in the file a list of eligible employees and/or eligible dependents.

Colorado Insurance Regulation 4-6-8, Concerning Small Employer Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-16-105.2(1)(a)(IV) and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, and 10-16-708, C.R.S., states in part:

> Section 5. Issuance Of Coverage
>
> B. Determining Who is an Eligible Employee, Dependent
>
> (2) *A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees, and a list of employer-determined eligible employees and dependents, if this is a different list.* The small employer carrier may require the small employer to provide appropriate supporting documentation, such as the Unemployment Insurance Quarterly Wage and Tax Report (UITR) often referred to as a W-2 Summary Wage and Tax Form, to verify the information required under this paragraph. In the event that a UITR form is not available because the employer was not in business during the preceding quarter or the employer has outsourced payroll functions, the carrier shall accept reasonable alternate documentation for this information. Alternate documentation includes, but is not limited to, payroll documentation from the company or the company's payroll administrator or employee leasing company; organizational documents; or other reasonable proof. [Emphasis added.]

SMALL GROUP NEW BUSINESS

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,104	50	24	48%

The examiners reviewed a randomly selected sample of fifty (50) files from a summarized population of 1,104 new small groups issued during the examination period. Based on the files reviewed it appears that the Company is not in compliance with Colorado insurance law in that twenty-four (24) of the files in the sample did not contain a list of eligible employees and/or eligible dependents.

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that it obtains a list of eligible employees and eligible dependents with each new group application, and retains these lists in the application files in order to comply with Colorado insurance law.

CANCELLATIONS/DECLINATIONS/TERMINATIONS/RESCISSIONS

Issue H1: Failure of the Company's Certificates of Creditable Coverage to address and/or define "significant break in coverage" in accordance with Colorado insurance law.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. *The method of crediting and certifying coverage shall be determined by the commissioner by rule*. [Emphasis added]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, states in part:

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

Section 5. Rules

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.

3. Application of the rules regarding breaks in coverage can vary between issuers located in different states, and between fully insured plans and self-insured plans within a state. The laws applicable to the health coverage plan that has the pre-existing condition exclusion will determine which break rule applies.

4. Certifying creditable coverage

   Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance *must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation.* [Emphasis added]

It appears the Company is not in compliance with Colorado insurance law in that its notice titled "Certificate of Creditable Coverage" does not address "significant break in coverage" or how it is defined, as required in Section 4. A. of Colorado Insurance Regulation 4-2-18.

The Company was unable to produce or recreate the actual Certificates of Creditable Coverage that were provided to members. Therefore, the examiners were unable to test the validity of the certificates that should have been provided. However, the Company did provide a "sample" Certificate of Creditable Coverage. This "sample" certificate was reviewed for compliance with Colorado insurance law, which resulted in the determination that it was not in compliance due to the failure to reflect the required definition of "significant break in coverage".

Form	**Form Number**
Certificate of Creditable Coverage	10330J 05/05

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-118, C.R.S., and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly reflect all required elements of the Certificates of Creditable Coverage in accordance with Colorado insurance law.

Issue H2: Failure of the Company to correctly underwrite small employer group applications.

Section 10-16-102, C.R.S., Definitions, states in part:

(6)(a) "Business group of one" means, for purposes of qualification, an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership who works twenty-four hours or more a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application for coverage, has taxable income as indicated on federal internal revenue service forms 1040, schedule C, F, or SE, or other forms recognized by the federal internal revenue service for income reporting purposes which generated taxable income in one of the two previous years or from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual's income for one year out of any consecutive three-year period. For the purposes of this subsection (6), "substantial part of such individual's income" means income derived from business activities for the business group of one that are sufficient to pay for annual health insurance premiums or the business group of one.

(b) "Business group of one" includes a full-time household employee who works twenty-four hours or more a week on a permanent basis as a household employee, if that employee has derived at least a substantial part of such employee's earned income for one year out of the preceding three-year period from household employment, and if the employee's employer, on at least fifty percent of the days in a normal work week during the preceding calendar quarter, employed at least one household employee.

(c) For purposes of determining whether an applicant meets the requirements of the definition set forth in this subsection (6), a carrier may require an applicant to submit to the carrier any of the following forms of documentation that is applicable to the applicant's current business or employment

(I) Employment related tax and withholding information, including, but not limited to, a federal revenue service form 1099; and

(II) Relevant portions of federal and state tax returns or a certification by an attorney or certified public accountant that federal and state tax returns have been filed as a business.

(40) "Small employer" means any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, the majority of whom were employed within this state and that was not formed primarily for the purpose of purchasing insurance. On and after January 1, 1996, "small employer" includes a business group of one. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic health benefit plans – rules – benefit design advisory committee - repeal, states in part:

(7.3)(a) Except as otherwise provided in this subsection (7.3), effective January 1, 1995, every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to such small employers the choice of a basic health benefit plan or a standard health benefit plan. Effective July 1, 1997, every small employer carrier shall also offer to small employers a choice of all the other small group plans the carrier markets in Colorado; except that this requirement shall not apply to a health benefit plan offered by a carrier if such plan is made available in the small group market only through one or more bona fide association plans and except as provided in paragraph (i) of this subsection (7.3).

(c)(I)Effective January 1, 1995, a small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for such health benefit plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with this article. Effective July 1, 1997, a small employer carrier shall also issue any of its other small employer plans to any small employer that applies for such a plan; except that this requirement shall not apply to a business group of one where the business group of one does not meet the carrier's normal and actuarially-based underwriting criteria. The requirements of this subparagraph (I) shall not apply to a health benefit plan offered by a carrier if such plan is made available in the small group market only through one or more bona fide association plans and except as provided in paragraph (i) of this subsection (7.3).

Colorado Insurance Regulation 4-6-8, Concerning Small Employer Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-16-105.2(1)(a)(IV) and (3), 10-16-105(5), 10-16-108.5(8) and 10-16-708, C.R.S., states in part the following:

Section 8. Special Provisions Applicable To Business Groups Of One

A. A small employer carrier may request documentation as necessary to determine whether a small employer meets the definition of a business group of one for purposes of obtaining and maintaining small group health coverage.

1. In order to determine whether a business group of one qualifies for small group health coverage, the business group of one must provide sufficient documentation that it has carried on significant business activity in the past year, and has gross income from active participation in the business for at least one year out of the most recent consecutive three-year period that is sufficient to pay for annual health insurance premiums for the business group of one.

2. In order to determine whether a business group of one has sufficient income to qualify for a carrier’s small group plans, the business group of one must provide tax documentation of the business’s gross income. The amount shall be determined using the gross income for the business as indicated on the appropriate forms recognized by the Federal Internal Revenue Service for business income reporting. For

corporations, the gross income is equal to total income reported to the Federal Internal Revenue Service.

3. If the business group of one meets all eligibility requirements but the gross income is insufficient for the specific plan requested, the carrier shall determine if the income is sufficient for another small group plan offered by the carrier. The carrier shall notify the employer and provide an opportunity to enroll in another plan for the same effective date.

4. A business group of one must provide sufficient information to show that the individual works full time (24 hours or more per week on a regular basis). In most situations, the nature of the business and the business income information should be sufficient to verify that the business group on one is working full time. In the event that the nature of the business or the tax information would indicate that the individual may not be actively engaged in business on a full-time basis, the carrier may request additional information to reasonably determine whether the individual is employed on a full-time basis. Additional information that may be requested includes:

   (a) Invoices, billing records, general ledgers or similar information for a portion of the past year not to exceed 3 months;

   (b) Additional tax documentation substantiating that business activities are not passive;

   (c) Organizational documents including business license, articles of incorporation, and by-laws as appropriate for the type of business; and

   (d) In the absence of the information listed above, the carrier may request business collateral materials including marketing materials, business forms, website addresses, or similar information in an effort to verify eligibility.

SMALL GROUP DECLINATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
36	29	6	21%

It appears that the Company is not in compliance with Colorado insurance law, in that in some instances, the Company failed to comply with the requirements of § 10-16-102, 10-16-105, C.R.S., and Colorado insurance regulation 4-6-8 as they relate to providing small employer groups with requested health benefit plan coverage.

The examiners reviewed the entire population of thirty-six (36) small employer group applications for coverage that were declined by the Company. Of the thirty-six (36) files reviewed, one (1) was determined to be a large group and two (2) involved requests for coverage other than medical (vision and dental). In four (4) other instances, the Company was unable to provide documentation for the requested files. The remaining twenty-nine (29) files were reviewed for compliance with Colorado insurance law.

Of the twenty-nine (29) files reviewed, the documentation provided indicated that six (6) files appeared to have met the minimum requirements to be eligible for small group coverage under Colorado insurance law, but were inappropriately denied by the Company.

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§10-16-102, 10-16-105 C.R.S., and Colorado Insurance Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its underwriting policies and procedures regarding small group declinations to ensure compliance with Colorado insurance law.

Issue H3: Failure, in some instances, to provide written denial of coverage and/or provide specific reason(s) for denial of coverage on small employer group applications. *(This was prior issue H2 in the findings of the market conduct examination report dated June 28, 2001.)*

Section 10-16-108.5, C.R.S., Fair marketing standards, states in part:

(7) Any denial by a carrier of an application for coverage from an individual or a small employer shall be in writing and shall *state any reason for the denial*. [Emphasis added.]

SMALL GROUP DECLINATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
36	33	33	100%

It appears that the Company is not in compliance with Colorado insurance law, in that in some instances, the Company failed to provide small employer applicants with a written notice of denial that included the reason for the denial of coverage.

The examiners reviewed the entire population of thirty-six (36) small employer group applications for coverage that were declined by the Company. Of the thirty-six (36) files reviewed, one (1) was subsequently identified by the Company as a large group, and two (2) were applications for coverage other than medical (vision and dental). The remaining thirty-three (33) files were reviewed for compliance with Colorado insurance law.

Of the thirty-three (33) files reviewed, two (2) did not provide any documentation that a written notification of the denial of coverage was provided to the applicants. Thirty-one (31) of the remaining files reviewed did reflect that the Company provided a written notice of denial; however, these notifications did not include the specific reasons for the denial of coverage. The examiners believe that providing a list of potential reasons for the denial of coverage was not sufficient to meet the requirements set forth under § 10-16-108.5, C.R.S.

Recommendation No. 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-108.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that written notification of denial that includes the specific denial reason is provided to all small group applicants who are denied coverage in accordance with Colorado insurance law.

In the market conduct examination for the period January 1, 2000 to December 31, 2000, the Company was cited for failure of the forms to provide for failure to issue declination notices in writing, stating the reasons for the denial of coverage. The violation resulted in Recommendation #46 of the Stipulated Final Agency Order O-02-120 that the Company "shall revise its underwriting procedures to ensure that written declinations stating reasons for denial of coverage are provided to all applicants." Failure to comply with the previous order of the Commissioner may constitute a knowing violation of §10-1-205, C.R.S.

Issue H4: Failure, in some instances, to provide price quotes upon request.

Colorado Insurance Regulation 4-6-5, Concerning the Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8) and 10-16-109, C.R.S., states in part:

Section 4. Rules

G. Quotes

1. A small employer carrier shall provide a price quote to a small employer (directly or through an authorized producer) within five (5) business days of receiving all information necessary to provide a requested quote. Each price quote must be calculated using the carrier's filed rate, as defined in Colorado Insurance Regulation 4-6-7.

2. A small employer carrier shall notify a small employer (directly or through an authorized producer) within five (5) business days of receiving a request for a price quote if any additional information is needed. If a small employer carrier provides a price quote prior to receiving all information necessary to calculate any premium adjustments allowed under §10-16-105(8.5)(a), C.R.S., that quote must be the filed rate. The quote shall include a statement indicating that the rate is not final, and once all information is received, the rate will be recalculated using rating factors allowable by law, and may vary from the initial price quote.

3. A price quote shall be provided without requiring verification of the eligibility of the small group, including business groups of one. The fact that a price quote has been issued shall not prevent the small employer carrier from verifying the group's eligibility before issuing the coverage.

5. Quotes for the basic and standard health benefit plans shall include quotes for each type of basic and standard health benefit plan the carrier markets (e.g., PPO, indemnity, HMO, HSA-qualified).

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of § 10-1-109(1), C.R.S., states in part:

Section 3. Definitions

F. "Declination" or "declination records" mean all written or electronic records concerning a policy for which an application for insurance coverage has been completed and submitted to an insurer or its producer but the insurer has made a determination not to issue a policy or not to add additional coverage when requested. Declined underwriting records shall include an application, any documentation substantiating the decision to decline issuance of a policy, any binder issued without the insurer issuing a policy, any documentation substantiating the decision not to add additional coverage when requested and, if required by law, any declination notification. Notes regarding requests for quotations that do not result in a completed application or coverage need not be maintained for the purposes of this regulation.

Section 12. Records Usually Required For Examination

F. Underwriting and rating practices: annual rate filing, company rating plan and rates, disclosures, producer payments, credit, deviations, schedule rating, IRPM plans, expense/loss cost multipliers, statistical coding/reporting, premium audits, loss reporting, policy forms and filings, underwriting policies, procedures, and manuals, declinations/rejections, cancellations, nonrenewals, rescissions, policyholder records (applications, policy riders, correspondence, policy forms), guaranteed issue, pre-existing conditions and privacy of protected personal information. [Emphases added]

SMALL GROUP DECLINATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
36	29	26	90%

It appears that the Company is not in compliance with Colorado insurance law, in that in some instances, the Company failed to provide small employer groups with the required price quotes for the requested coverage.

The examiners reviewed the entire population of thirty-six (36) small employer group applications for coverage that were declined by the Company. Of the thirty-six (36) files reviewed, one (1) was subsequently identified by the Company as a large group, and two (2) were applications for coverage other than medical (vision and dental). In four (4) other instances, the Company was unable to provide documentation for the requested files.

Of the remaining twenty-nine (29) files reviewed, the documentation provided indicates that in twenty-six (26) instances, the Company failed to provide the required rate quote for the coverage requested by the small employer groups.

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulations 4-6-5 and 1-1-7. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that prospective small employer groups are provided with price quotes in accordance with Colorado insurance law.

Issue H5: Failure, in some instances, to implement procedures for terminating policies, including coding and timing of cancellation processing, and providing offers of Basic and Standard coverage that are in compliance with Colorado insurance law.

Section 10-16-102, C.R.S., Definitions states, in part:

(21)(a) "Health benefit plan" means any hospital or medical expense policy or certificate, hospital or medical service corporation contract, or *health maintenance organization subscriber contract* or any other similar health contract subject to the jurisdiction of the commissioner available for use, offered, or sold in Colorado.

(26) "Late enrollee" means an eligible employee or dependent who requests enrollment in a group health benefit plan following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, if such initial enrollment period is a period of at least thirty days. *An eligible employee or dependent shall not be considered a late enrollee if:*

(a) The individual:

(III) Requests enrollment within thirty days after termination of the other creditable coverage; or

(d) A person becomes a dependent of a covered person through marriage, birth, adoption, or placement for adoption and requests enrollment *no later than thirty days after becoming such a dependent.* In such case, coverage shall commence on the date the person becomes a dependent if a request for enrollment is received in a timely fashion before such date.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states in part:

(4) Special provisions for small group health benefit plans.

(a) Effective January 1, 1995, *each small employer carrier shall, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan, except as provided in paragraph (b) of this subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel.*

(b) If the group's original plan had benefits which were significantly less generous in most respects than the standard plan as determined by the commissioner, the carrier is only required to offer the basic health benefit plan to such group or individual. If an individual is eligible for continuation coverage or conversion coverage pursuant to section 10-16-108 or is eligible for continuation coverage under federal law, then the provisions of paragraph (a) of this subsection (4) and this paragraph (b) shall not apply to such an individual.

(c) *Each small employer carrier shall offer the choice of a basic or standard health benefit plan to any individual who loses nexus to existing small group coverage; …*

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) *Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage.* The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. The method of crediting and certifying coverage shall be determined by the commissioner by rule.

(c) *Shall exclude coverage for late enrollees for the greater of twelve months or for no more than an eighteen-month-preexisting condition exclusion; except that, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan.* Health maintenance organizations that do not use preexisting condition exclusion periods in any of their plans may impose up to a three-month affiliation period in lieu of the eighteen-month preexisting condition period. [Emphases added.]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, states in part:

Section 4.Definitions

B. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. *For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.*

Section 5. Rules

B. Colorado law concerning creditable coverage.

5. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

6. *Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.*

7. Application of the rules regarding breaks in coverage can vary between issuers located in different states, and between fully insured plans and self-insured plans within a state. The laws applicable to the health coverage plan that has the pre-existing condition exclusion will determine which break rule applies.

C. Maximum six (6) month pre-existing condition exclusion period for group health plans.

Colorado law prohibits group health plans from imposing a pre-existing condition limitation period that exceeds six (6) months, except with respect to late enrollees as provided for in Section 10-16-118(1)(c), C.R.S. All references in the federal regulations to twelve (12) month pre-existing condition limitations for group health benefit plans are not applicable in Colorado.

D. Student health plans are considered group health plans.

Colorado law considers student health benefit plans to be group plans. *As such, student health plans shall comply with the group health benefit plan provisions of Colorado law including those related to pre-existing condition limitations.*

E. Children's Basic Health Plan is considered a group health plan.

Colorado law considers the Children's Basic Health Plan (also known as CHP+) to be a group plan. *As such, carriers offering coverage through the Children's Basic Health Plan shall comply with the group health benefit plan provisions of Colorado law.*

F. Treatment of late enrollees.

Colorado law requires late enrollees (i.e., those individuals who did not enroll when initially offered coverage and who are not special enrollees pursuant to section 10-16-102(26), C.R.S.) to be enrolled upon request. *However, late enrollees are subject to longer pre-existing condition periods, affiliation periods, and waiting periods for coverage, as provided for in Section 10-16-118(1)(c), C.R.S.*

HMO CANCELLATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
230	46	46	100%

The examiners reviewed a total of forty-six (46) cancellation files randomly selected from a total population of 230 files. This included a second sample requested after the examiners determined the first sample included forty-one (41) files that appeared to be conversions to other plans or groups rather than cancellations (some of which were still active), and files with cancellation effective dates outside the time frame of the examination. The second sample included one (1) file that was a duplicate of a file from the first sample, and three (3) of the original sample files retained were found to have cancellation dates effective outside the examination period. Therefore, these four (4) files were excluded from the sample which resulted in the adjusted sample of forty-six (46) files reviewed.

It appears the Company's procedures for terminating policies, including coding and timing of cancellation processing, and providing offers of basic and standard coverage are not in compliance with Colorado insurance law in several ways:

Issue 1: The examiner was unable to find documentation in any of the forty-six (46) files to determine whether an offer of basic or standard coverage was made for those policies cancelled due to:

(1) the group no longer meeting group requirements,
(2) non-payment of premium,
(3) policyholder exercising the right to cancel and not replace with another group policy.

Failure to provide documentation in each case supporting that either basic or standard coverage was offered appears to be a lack of compliance with the required offer.

Issue 2: It appears the Company has recorded contradictory information and coded reasons for cancellation incorrectly. This appears to have resulted in the Company's failure to provide required offers of basic or standard coverage in some situations. The Company provided screen prints, documentation, and/or a code on a spreadsheet which contradicted each other and/or the explanatory information the Company provided regarding the definitions of cancellation reason codes. The examiner is unable to determine in some cases from the contradictory information and lack of other supporting information, whether offers of basic or standard coverage were required, or were sent when required.

Six (6) of the forty-six (46) files contained discrepancies between the reason codes indicated on the screen prints, the reason codes indicated in the spreadsheet, and when provided, separate documentation of reasons for cancellation in the system file notes or written communications.

- Three (3) of the six (6) files indicated reason code "89" - "group request"; however, file documentation indicates the policy should have been coded "47" or "DU" - cancellation for non-payment of premium, which requires an offer of basic or standard coverage,

- One (1) file indicted reason code "47" or "DU" – cancellation for non-payment of premium or 19 WLP Conversion; however, documentation provided indicates the policy should have been coded "89" - "group request", which may have required an offer of basic or standard coverage,

- One (1) file indicated reason code "89" – "group request", while documentation indicated the policy should have been cancelled with reason code "28" - "no longer qualifies as a group", which requires an offer of basic or standard coverage,

- One (1) file indicated the cancellation effective date as 30 days prior to the date the member requested.

Issue 3: It appears that in some cases, the Company has terminated policies retroactively in violation of Colorado insurance laws. In twenty-seven (27) of the forty-six (46) files, terminations were processed more than thirty (30) days after the termination effective date. The time periods ranged from thirty-five (35) days to three hundred and fifteen (315) days after the termination effective date, and included twenty-one (21) policies for which terminations were processed ninety (90) days or more after the effective date. These delays in processing may have caused a significant break in coverage for the members of these twenty-one (21) groups.

When a contract is terminated thirty (30) or more days retroactively, the member cannot be aware of the default in sufficient time to exercise his or her right to elect any alternative coverage to which he or she would otherwise be entitled whether through the carrier via or another carrier through another group or individual plan. In addition, in all likelihood the member has already paid premium to the defaulting employer for the terminated group coverage, and would most likely have to pay additional premium for any alternative coverage he or she may be entitled to.

To summarize, a member who is not given sufficient advance notice of termination of the group contract so that application for alternative coverage can be made within any applicable time frame:

- May lose the right to guaranteed issuance of alternative group health coverage upon the occurrence of, for example, a change in family status;

- May lose the right as a federally eligible individual to guaranteed issuance of an individual policy;

- May be considered a late applicant subject to a pre-existing condition limitation under a new policy or contract; and

- May incur health care expenses after paying his or her premium contribution believing in good faith that health coverage is in force, only to find out later that he or she is liable for those medical costs.

Recommendation No. 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-108, 10-16-118, C.R.S. and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its termination procedures to comply with Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.*
>
> (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.
>
> *(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphasis added.]

ELECTRONIC CLAIMS PROCESSED OVER 30 CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
77, 457*	49	46	94%

(*11% of all electronic paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) electronic claims from a total summarized population of 77,457 electronic claims that had not been paid, denied or settled within thirty (30) calendar days after receipt. One (1) file was subsequently removed after it was determined to be from a member of a self-funded group. It appears the Company is not in compliance with Colorado insurance law in that forty-six (46) of the remaining forty-nine (49) electronic claims in the sample, while appearing to be clean claims, were not paid, denied, or settled within thirty (30) calendar days after receipt.

NON-ELECTRONIC CLAIMS PROCESSED OVER 45 CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
21,498*	50	45	90%

(*12% of all non-electronic paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) non-electronic claims from a total summarized population of 21,498 non-electronic claims that had not been paid, denied or settled within forty-five (45) calendar days after receipt. It appears that the Company is not in compliance with Colorado insurance law in that forty-five (45) of the non-electronic claims in the sample, while appearing to be clean claims, were not paid, denied, or settled within forty-five (45) calendar days after receipt.

CLAIMS PROCESSED OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
15,816*	50	31	62%

(*2% of all paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) claims from a total summarized population of 15,816 claims that had not been paid, denied or settled within ninety (90) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that thirty-one (31) of the claims in the sample were not paid, denied or settled within the required ninety (90) calendar days after receipt.

Recommendation No. 24:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all claims are paid, denied, or settled within the time frames required by Colorado insurance law.

UTILIZATION REVIEW

Note: The findings in the Utilization Review Section (except Issue K3) were identified in the market conduct examination of HMO Colorado, Inc., but were deemed to also apply to Rocky Mountain Hospital and Medical Service, Inc.

Issue K1: Failure, in some instances, to provide written notification of first level review adverse determinations within the time frame required by Colorado insurance law.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 10. First Level Review

G. (1) A health carrier shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in Paragraph (2) or (3).

(2) With respect to a request for a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, *but no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review*.

(3) With respect to a request for a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time, *but no later than thirty (30) days after the date of the health carrier's receipt of a request for the first level review*. [Emphases added.]

FIRST LEVEL REVIEW ADVERSE DETERMINATIONS –Written notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,215	50	5	10%

The examiners reviewed a randomly selected sample of fifty (50) HMO utilization review first-level appeal files initiated by "covered persons" or their representatives during the examination period. Each of the fifty (50) first-level appeal files reviewed appeared to be subject to the provisions of Section 10 of Regulation 4-2-17.

It appears that the Company did not meet the requirements of Colorado insurance law in that in five (5) out of the fifty (50) first-level appeal files reviewed, the Company's written notification letter was not provided to the covered person within the thirty (30) day maximum time frame set forth in Colorado Insurance Regulation 4-2-17(10)(G)(2) and (3).

Recommendation No. 25:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that it provides written notification letters regarding appeals within the time frames required by Colorado insurance law.

Issue K2: Failure to provide the location of the review panel meeting and thereby discouraging the covered person from requesting a face-to-face meeting.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 11. Voluntary Second Level Review

A. A carrier may establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision the option to request a voluntary second level review, at which the covered person has the right to appear in person at the review meeting before designated representatives of the carrier. The procedures shall allow the covered person to identify providers to whom the health carrier shall send a copy of the review decision…

G. A health carrier's procedures for conducting a voluntary second level panel review shall include the following:

(2) *Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting*. Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, including accommodations for disabilities. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. [Emphases added.]

VOLUNTARY SECOND LEVEL APPEALS – Notification of Review Panel Meeting

Population	Sample Size	Number of Exceptions	Percentage to Sample
8	4	4	17%

The examiners reviewed the Company's entire population of eight (8) voluntary second-level utilization review appeal files initiated by "covered persons" or their representatives during the examination period. Of the eight (8) files reviewed, two (2) contained decisions that were overturned prior to review by the review panel and two (2) others were subsequently determined to be benefit denials that were not subject to the above utilization review requirements and therefore were not reviewed. The remaining four (4) files were cases where the review panel was scheduled.

It appears that the Company did not meet the requirements of Colorado insurance law in that in all four (4) of the files reviewed, the Company discouraged the covered person and/or their representative(s) from requesting a face-to-face meeting as set forth in Colorado Insurance Regulation 4-2-17(11)(A) and (G)(2) by not fully disclosing the location of the review panel meeting.

Recommendation No. 26:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that disclosure of the location of the review panel meeting is provided, and that it does not in any way discourage covered persons and/or their representatives from requesting face-to-face meetings as required by Colorado insurance law.

Issue K3: Failure to include dental services in the Company's UR procedures.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition ad unfair or deceptive acts or practices in the business of insurance:

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(II) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies; or
(III) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; or
(IV) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 2 Background and Purpose

The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of Sections 10-3-1104(1)(h), 10-16-409(1)(a) and 10-16-113, C.R.S., in situations involving utilization review and certain denials of benefits for treatment, as described herein. Among other things, Section 10-3-1104(1)(h), C.R.S., requires carriers to adopt and implement reasonable standards for the prompt investigation of claims arising from insurance policies; promptly provide a reasonable explanation of the basis of the insurance policy in relation to the facts or applicable law for denial of a claim or the offer of a compromise settlement; and refrain from denying a claim without conducting a reasonable investigation based on all available information. This regulation replaces Colorado Emergency Regulation 05-E-5 in its entirety.

Section 3 Applicability and Scope

The provisions of this regulation shall apply to all health coverage plans, but shall not apply to automobile medical payment policies, worker's compensation policies or property or casualty insurance. Where a decision concerning a claims is not based on utilization review, a carrier is not required to use the specific procedures outlined in this regulation, except this regulation shall apply to a carrier's denial of a benefit because the treatment is excluded by the health coverage plan if the covered person present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply. Nothing in this regulation shall

be construed to supplant any appeal or due process rights that a person may have under federal or state law.

Section 4 Definitions

S. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion certification, concurrent review, case management, discharge planning, or retrospective review. For the purposes of this regulation, utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

Section 5 Compliance Requirements

A. A health carrier that does not use a procedure for investigating claims involving utilization review that is consistent with this regulation shall be deemed not to be in compliance with the requirements under the unfair competition and deceptive practices insurance statutes of Colorado that a carrier refrain from denying a claim without conducting a reasonable investigation based on all available information.
(Section 10-3-1104(1)(h)(IV), C.R.S.)

It appears that the Company is not in compliance with Colorado insurance law in that for portions of calendar year 2006, the Company did not have a utilization review procedure in place for the review of dental claims. In response to an examiner inquiry regarding the Company's utilization review procedures in connection with dental services, the Company stated the following:

"The UM/UR process for dental claims started in 2006 as groups converted from the ADV system to the WDS system. This was a phase conversion based on renewal dates. Prior to conversion there was no UM/UR process."

Recommendation No. 27:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S., and Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that dental services are included in the utilization review process in the same manner as medical services, to ensure compliance with Colorado insurance law.

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